PRINTED: 01/31/2007

		& MEDICAID SERVICES			, == ,		APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLET	RVEY
	· ·	09G097	B. WING			01/24	1/2007
' NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, SYATE, ZIP CODE		
CARECO	0 03			1	1447 OAK STREET, NW WASHINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
W 000	INITIAL COMMENT	rs	W	000			
W 104	January 23, 2007, the utilizing the fundame clients with varying in this facility. Two crandomly selected the survey were based on the review records, reports.  483.410(a)(1) GOV  The governing body budget, and operation of records, the facility, as evidenced. The findings includes 1. The Governing Inconsistent staffing the foliation of the consistent staffing the staffing the foliation of the consistent staffing the	y must exercise general policy, ing direction over the facility.  Is not met as evidenced by: ons, interviews and the review ity's Governing Body failed to erating direction over the ed by the following:  Body failed to ensure to facilitate Client #1's graming at the day program as	w	104	The QMRP and the Director of D Services will ensure that all staff are thoroughly trained on support client in the home whether for 1:1 staffing requirements. The QMRP coordinate with the Day Program provide specific program training staff, thus ensuring that when staff must change, all staff are familiar competent to support all clients in Program or in the home.	at the home ing every or general will staff to for all facili f assignmen with and	s 3/9/2007

that the group home provided the staffing for the LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

On January 23, 2006, at 10:19 AM, the surveyor made an on-cite visit to Client #1's day program. In an interview with the day program staff it was discovered that Client #1 requires one-on-one supervision. The day program staff indicated

(XII) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1Y8P11

Facility ID: 09G097

If continuation sheet Page 1 of 21

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES  & MEDICAID SERVICES			PRINTED: 01/3 FORM APPI	ROVED	
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A BUILI	LTIPLE CONSTRUCTION DING	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
<u> </u>	·	09G097	B. WING				
NAME OF	PROVIDER OR SUPPLIER		Ts	TREET ADDRESS, CITY, STATE, ZIP CODE	01/24/200	07	
CAREC	· · · · · · · · · · · · · · · · · · ·			1447 OAK STREET, NW WASHINGTON, DC 20010			
(X4) ID PREFIX YAG	) (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE COOSE   COM	X5) PLETION ATE	
W 104	one-to one supervis providing the one to She indicated that O staff and the next w staff assigned. Who staffing affected the programming, the d that whenever the c person he would ref programs. The day indicated that it was constantly have to tractional programs.  2. The governing be administrative process implemented to obtain for Clients #2 and #3 procedures resulted ensure the timely comedical procedures W124, 2-3) 483,420(a)(2) PROT RIGHTS  The facility must ensure the client's medical procedures the traction of the client's medical and behavioral statutes and behavioral statutes the sased on staff intervisacility failed to ensure established to obtain	cion, however the person one was very inconsistent. Client #1 would be used to one eek there would be another en asked if the changes in clients behavior or ay program staff indicated lient was with a new staff use to participate in his program staff further very difficult to continue to rain the new staff on the cody failed to ensure dures were effectively ain surrogate decision makers in the facility's failure to mpletion of recommended for Clients #2 and #3. [See ECTION OF CLIENTS cure the rights of all clients, a must inform each client, a milnor), or legal guardian, al condition, developmental	W 10	The QMRP will submit guardiansh application packages for all clients to DDS (MRDDA) per the District The QMRP and the Director of Dis Services will track the progress of guardianship applications with Cas until guardians are successfully ass	ip in the home 's protocol. ability the e Managers igned. 3/9		

FORM CMS-2567(02-99) Previous Varsions Obsolete

Event ID: 1Y8P11

Facility ID: 09G097

If continuation sheet Page 2 of 21

		A MAIN HOIMAN SERVICES				PRINTED	: 01/31/2007
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			•	FORM	APPROVED
ISTATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) A		IPLE CONSTRUCTION	(X3) DATE S COMPLE	
	•	09G097	B. WI	NG_		}	
NAME OF	PROVIDER OR SUPPLIER	400007				01/2	4/2007
	CAREGO 03.			1	REET ADDRESS, CITY, STATE, ZIP CODE 447 OAK STREET, NW		•
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	- 15	<u> </u>	VASHINGTON, DC 20010	<del>.</del>	
PREFIX TAG	{EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	BE CDOSS	COMPLETION DATE
W 124	Continued From pa	ge 2	W	124			<u> </u>
	residing in the facility	ty. (Clients #1, #2, and #3)	**	127			
	The findings include	<b>:</b> : .					·
	1. The facility failed	to obtain consent for the use					
		its administration for Client #1.					
	received Ativan 3 m the 24th revealed th	s medical record on January that on February 9, 2006, he g. Interview with the nurse on e medication was o the client having his blood					,
	Retardation Profess 2007, revealed that guardian, however h	th the Qualified Mental  Jonal (QMRP) on January 23,  Client #1 does not have a					
	was no other person	e record failed to evidence the sister, additionally, there or entity identified in the rized as a surrogate decision					
	revealed Client #1 remedication and has	QMRP on January 23, 2007 eceives psychotropic a behavior support plan. I revealed that Client #1					
	receives Paxil 37.5 r anxiety. Further inte revealed Client #1 ha	ng daily for depression and oview with the QMRP	٠				
	of the survey, there v Behavior manageme psychotropic medica	was no consent for the ent plan or the use of tion. Further there was no dentified as having					
1.	January 23, 2007 at :	medication nurse on 5:42 PM revealed that Client ing Tab by mouth each					

CENTERS FOR MEDICARE & MEDICAID SERVICES FORM AP	1/31/2007 PRÓVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  (X3) DATE SURV COMPLETED  (X4) MULTIPLE CONSTRUCTION  (X5) DATE SURV COMPLETED	ŒY
09G097 B, WING	007
NAME OF PROVIDER OR SUPPLIER  CARECO 03  STREET ADDRESS, CITY, STATE, ZIP CODE 1447 OAK STREET, NW WASHINGTON, DC 20010	007
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S BLANCE CONTROLLED	(X5) DMPLÉTION DATE
M 124  Continued From page 3  morning for behavior. Record verification on January 23, 2007 confirmed that the client is prescribed and is administered this medication. The review of the Comprehensive Psychiatric Assessment revealed an Axis I diagnosis of Intermittent Explosive Disorder. According to Client #1's Psychological Assessment dated 2006, the client functions in the moderate range of mental retardation cognitively and the profound range adaptively. Further, the psychological assessment revealed the client is not cognitively competent to make independent decisions on her hear behalf regarding her habilitation planning, placement, financial, and medical matters.  Interview with the QMRP on January 23, 2007, as well as the record review revealed that Client #1 does not have a legally-sanctioned guardian and/ or a surrogate health care decision-maker to review and approve the use of the restrictive interventions. There was no evidence a legally authorized representative had been identified to represent the client in the aforementioned areas identified in the psychological assessment.  4. a. Cross refer to W322, 1 The facility failed to ensure a legally authorized representative to sign the consents for recommended medical and dental procedures for Clients #2 and #3.  Interview with the nurse on January 24, 2007 revealed that Client 2 was Initially recommended to have an EMB (endometrial biopsy) was on December 29, 2005 however, the procedure had not been performed. Further interview with the nurse and the review of the Human Rights Committee (HRC) minutes dated February 23, 2006 revealed the HRC approved the procedure.	

DEPAR	RTMENT OF HEALTH	I AND HUMAN SERVICES					D: <b>0</b> 1/31/200	
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FORM	M APPROVE 2. 0938-039	D
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION NG	(X3) DATE :	SURVEY	1
) 		09 <b>G</b> 097	B. Wi	NG_		}		
NAME OF	PROVIDER OR SUPPLIER		<b>_</b>	T		01/	24/2007	
CAREC		<u>.                                      </u>		)	REET ADDRESS, CITY, STATE, ZIP CODE 1447 OAK STREET, NW WASHINGTON, DC 20010			
(X4) ID PREFIX TAG	! (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	DE COORE	(X5) COMPLETION DATE	-
W 124	Continued From page 4					·· <del>·</del> -·	<del> </del>	_
•	needed to have a si procedure to be per QMRP and the reco 2007 revealed that t completed because authorized represen form. The QMRP in	gned consent for the formed. Interview with the rd verification on January 24, the procedure had not been the client did not have an tative to sign the consent dicated numerous efforts.	<b>W</b> 1	124		•		
	made to contact the consent were unsuc evidence, however, -maker had been ob	client's brother to sign the cessful. There was no a guardian/surrogate decision tained to ensure the ended to assess the client's						
W 153	minutes dated Febru committee approved dental rehabilitation of January 24, 2007 with nurse and the QMRF contact the brother to unsuccessful. Further and the QMRP howe still had not been sof	7322, 2. The review of HRC rary 23, 2006 revealed the sedation for full mouth for Client #3. Interview on the home manager, the indicated initial attempts to o sign the consents were er Interview with the nurse ever, indicated the procedure neduled or performed due to authorized representative to	W 18	53				
	mistreatment, neglec injuries of unknown s immediately to the ad officials in accordance established procedure.	Iministrator or to other e with State law through es.			The Director of Disability Services and revise current facility policies to they meet legal requirements for incidentification, reporting, investigation corrective actions. The Director of I Services will ensure that all staff are proper policies and protocols in the identification, reporting, investigation	o ensure cident on, and Disability c trained or on, and	n	
	Based on Interview at	not met as evidenced by: nd review of the records, the			corrective actions for client incident	<b>S.</b>	3/9/07	
RM CMS-256	7(02-99) Previous Versions Ob	solete Eural (D. 4)49944						1

NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LTIPLE CONSTRUCTION DING	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
	09G097	B. WING			
Provider or supplier O 03		s	1447 OAK STREET, NW	01/24/2007 P CODE	
+ (EACH DEFICIENC)	MUST BE PRECEDED BY CO.	ID PREFIX TAG	PROVIDER'S PLAN OF CORR	II D DE COOSS	(X5) COMPLETIC DATE
facility falled to ensinformed of injuries accordance with Di 35, Section 3519.1(sample, (Client #2)	ure that outside agencies were of unknown origin in strict Law 22 DCMR, Chapter of one two clients in the	W 15	3		
The facility failed to #2's discomfort which	investigate the origin of Client				
slight limping on bot client held her knear facial grimace noted during gross motor. Mental Retardation I Will notify the PCP	program staff "Observed th legs. Upon standing up s, as though they hurt. No I. Unable to use the treadmill Spoke with the Qualified Professional (QMRP) about it				
22, 2007 falled to pridiscomfort of unknowimmediately to the a officials through esta accordance with Sta 483.420(d)(3) STAFI CLIENTS	ovide evidence the client's wn origin was reported dministrator or to other ablished procedures in te law. F TREATMENT OF	W 154	See response to W153.	·	3/9/o7
This STANDARD is Based on interview a failed to thoroughly in	not met as evidenced by: and record review, the facility				•
	Summary STANDARD is Based on interview a failed to thoroughly in the Violations are thoroughly in the STANDARD is Based on interview a failed to the thoroughly in the STANDARD is Based on interview a failed to the thoroughly in the Violations are the Violations are the Violations are thoroughly in the Violations are the Violation	DENTIFICATION NUMBER:  09G097  PROVIDER OR SUPPLIER  O 03  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 5 facility failed to ensure that outside agencies were informed of injuries of unknown origin in accordance with District Law 22 DCMR, Chapter 35, Section 3519.10 for one two clients in the sample. (Client #2)  The finding includes:  The facility failed to investigate the origin of Client #2's discomfort which was reported to the group home by the day program.  According to a day program quarterly report dated June 13, 2006, day program staff "Observed slight limping on both legs. Upon standing up client held her knees, as though they hurt. No facial grimace noted. Unable to use the treadmill during gross motor. Spoke with the Qualified Mental Retardation Professional (QMRP) about it Will notify the PCP". Interview with the QMRP and the review of unusual incidents on January 22, 2007 falled to provide evidence the client's discomfort of unknown origin was reported immediately to the administrator or to other officials through established procedures in accordance with State law.  483.420(d)(3) STAFF TREATMENT OF	DENTIFICATION NUMBER  A BUILT  BY MING  BY MING	DENTIFICATION NUMBER  096097  PROVIDER OR SUPPLIER  0 03  SUMMARY STATEMENT OF DEFICIENCIES (BACH DEFICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LISC IDENTIFYING INFORMATION)  Continued From page 5  facility failed to ensure that outside agencies were informed of injuries of unknown origin in accordance with District Law 22 DCMR, Chapter 35, Saction 3519.10 for one two clients in the sample. (Client #2)  The finding includes:  The facility failed to investigate the origin of Client #2's discomfort which was reported to the group home by the day program quarterly report dated June 13, 2006, day program staff "Observed slight limping on both legs. Upon standing up client held her knees, as though they hurt. No facial grimace noted. Unable to use the treadmill during gross motor. Spoke with the Qualified Mental Retardation Professional (QMRP) about it Will notify the POP". Interview with the QMRP and the review of unusual incidents on January 22, 2007 failed to provide evidence the client's discomfort of unknown origin was reported immediately to the administrator or to other officials through established procedures in accordance with State law.  483.420(d)(3) STAFF TREATMENT OF CLIENT'S  The facility must have evidence that all alleged violations are thoroughly investigated.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate Client #20's	DEMTIFICATION NUMBER  099097  A BUILDING  SUMMARY STATEMENT OF DEPICEMORS (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION)  CONTINUED From page 5  facility failed to ensure that outside agencies were informed of injuries of unknown origin in accordance with District Law 22 DORR, Chapter 35, Section 3519, 10 for one two clients in the sample. (Client #2)  The facility failed to investigate the origin of Client #2's discomfort which was reported to the group home by the day program staff "Observed Slight limping on both legs. Upon standing up client held her knees, as though they hurt. No facial grifmace noted. Unable to use the treadmill during gross motor. Spoke with the Qualified Mental Retardation Professional (QMRP) about it. Will notify the PCP". Interview with the QMRP and the review of unusual incidents on January 22, 2007 failed to provide evidence the client's discomfort of unknown origin was reported immediately to the administrator or to other officials through established procedures in accordance with State law.  483,420(9)(3) STAFF TREATMENT OF CLIENTS  The facility must have evidence that all alleged violations are thoroughly investigated.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to investigate Client's failed to the provides and record review, the facility failed to provide and review the facility failed to the provides and record review, the facility failed to the provides and record review, the facility failed to the provides and record review, the facility failed to the provides and record review, the facility failed to the provides and record review, the facility failed to the provides and record review, the facility failed to the provides and record review, the facility failed to the provides and record review.

Event ID: 1Y8P11

Facility ID: 09G097

If continuation sheet Page 6 of 21

STATEMEN	NT OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	OCOL MATERIA	IPLE CONSTRUCTION	OMB NO.	APPROVE . 0938-039
AND PLAN	OF CORRECTION	DENTIFICATION NUMBER:	A BUILDIN		(X3) DATE 51 COMPLE	
		09 <b>G</b> 097	B. WING _		04/2	4/5000
NAME OF	PROVIDER OR SUPPLIER		sπ	REET ADDRESS, CITY, STATE, ZIP CODI		<u>4/2007</u>
CAREC			1	447 OAK STREET, NW VASHINGTON, DC 20010	•	
(X4) ID PREFIX TAG	I (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	I har cooce	COMPLETION DATE
W 154	Continued From pa	age 6	W 154			
	Investigate the orig	W153] The facility failed to in of Client #2's discomfort by the day program.				
	unusual incidents of provide evidence the	QMRP and the review of in January 22, 2007 failed to be origin of the client's in mobility status was		±'		
W 159	483.430(a) QUALIF RETARDATION PF Each client's active integrated, coording	TIED MENTAL ROFESSIONAL treatment program must be ated and monitored by a ardation professional.	W 159	The Director of Disability Servi the QMRP is fully inserviced an all aspects of developing and im active treatment at every opport clients served. The Director of I	nd supported in aplementing unity for all Disability	
	review, the facility fa treatment programs and monitored by the Retardation Profess	s not met as evidenced by: on, interview and record ailed to ensure active were integrated, coordinated the Qualified Mental sional (QMRP) for three of the in the facility. (Clients #1, #2		Services will hold weekly indivisessions with the QMRP to deve implement, document, and revisinformal active treatment interversecommendations.	elop, train, se formal and entions and	3/9/07
	The findings include	<b>:</b> :				
	treatment intervention were employed at e	I to ensure that active ons and recommendations very available opportunity in or Client #1. [See W249]				
	services necessary f #1 and #2. [See W1	i to effectively coordinate to obtain consents for Clients 24]				
W 192	483.430(e)(2) STAF	F TRAINING PROGRAM	W 192			

Event ID: 1Y8P11

Facility ID: 09G097

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STATEME	ENT OF DEFICIENCIES	& MEDICAID SERVICES			FORN	APPROVE
AND PLAI	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
		0 <b>9G</b> 097				
NAME OF	PROVIDER OR SUPPLIER				01/2	4/2007
CAREC	CARECO 03			TREET ADDRESS, CITY STATE, ZIP COD 1447 OAK STREET, NW WASHINGTON, DC 20010	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHOI REFERENCED TO THE APPROPRIA	II D DE ABAR-	(X5) COMPLETION DATE
W 192	Continued From pa		<del></del>			<u> </u>
	For employees who	work with clients, training	W 192	The Director of Disability Service coordinate with the Director of QMRP, and outside supports su Health Resources Partnership, to	Nursing, the ch as the DC develop healt	th
	failed to ensure hear	not met as evidenced by: and record review, the facility th care interventions in th client's needs, for one of sample. (Client #1)		support protocols and train/men staff to implement them. The D Disability Services will also per Quality Assurance checks, and to Quality Assurance Department monthly monitoring to ensure the	tor all facility irector of form weekly he facility's will provide at staff are we	1
	The findings include	_		versed in all procedures and are and documenting accurately and	implementing	a 1
	the client to drink wa reluctantly drank the approximately 75% of the juice. The survey receiving Diocto 25 n	007, the surveyor observed unch. The staff encouraged ter and juice. The client water and was noted to drink if it. He also drank 75% of or observed the client observed with the nurse rified that he received the pation.				
	monitored. Review of failed to evidence door of fluids the client con	the fluid intake record sumentation of the amount sumed. Interview with the				
	2. On January 23, 20 Client #1 eating his lu a pureed grilled chees soup. The client cons sandwich and approxithe surveyor observer	07, the surveyor observed nch. The staff fed the client se sandwich and tomato umed 100% of the mately 75% of the soup.				

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Facility ID: 09G097

O I WIENTEN	L OF DEFICIENCIES	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	<del></del>		OMB NO	MAPPROV 0. 0938-03	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	JUTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED		
_		09G097	B. WING	3			
NAME OF P	ROVIDER OR SUPPLIER	000031	<del></del>		01/2	24/2007	
CARECO	03		1	STREET ADDRESS, CITY. STATE, ZIP COL 1447 OAK STREET, NW	PE .		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	10	WASHINGTON, DC 20010			
PREFIX TAG	TEACH DEFILIENCS	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHOI REFERENCED TO THE APPROPRIA	U.S. O.S	(X5) COMPLETIC DATE	
W 192	Continued From pa	ge 8	W 19	92			
1							
	Review of the Healt	h Management Care Plan					
	monitored. Review	fluid intake should be of the fluid intake record				1	
1	railed to evidence do	Ocumentation of the accura-				,	
1.	or indice the citent or	onsumed. Interview with the his information should have					
	neen dochilletied"						
W 212	483.440(c)(3)(I) IND	IVIDUAL PROGRAM PLAN	W 21	2			
.	The comprehensive	functional assessment must		The Director of Disability Servi	ces and the		
1 1	identity the presentir	IO Dioblems and disabilities.		Director of Nursing will review records to ensure that all assessi	the client		
1	and where possible,	their causes.		individual program plans are co	ordinated and		
	This or the			consistent with the needs identify	ied in the		
Ė	Inis STANDARD is Based on interview =	not met as evidenced by: and record review the facility		Comprehensive Functional Asso other clinical assessments. The	essment and		
, ,		VCDISTRIC Secondary and trans		Nursing will ensure that all Hea	Ith Care		
1 5	rocamenten in the le	COTO for one (Client #4) as		Management Plans are reviewed	and updated		
, , , ,	neuleauons, and taik	hple receiving psychotropic ed to include the diagnoses		appropriately. The Director of N conduct "grand rounds" at least	Jursing will		
1 4	a consupation and d	CD(CSS)OD for one alies ( )		ensure that medical and health s	upports and		
-	viient #1) receiving n	nedication to treat the		follow up are coordinated and pr	roperly		
_				implemented and documented. response to W159.	Also see	- 6/-	
	he finding includes:					3/9/0/	
lr	terview with the Qu	alified Mental Retardation					
1 -	iniessional(OMKb)	00 January 22, 2007		1			
1 141	evealed Client #1 red redication and had a	behavior cupport plan					
IN	eview of the record :	revealed that Client 44					
ar	nxiety. Further reco	g dally for depression and review, however revealed					
1	ACCOUNTIFIED BAIDS	DCG IDSI S Devekiatria					
44	ssessment was cond liagnosis for which t	lucted to determine an Avia					
	4190110615 TOF Which *	De Modiostias		f			

Event ID: 1Y8P11

Facility ID: 09G097

If continuation sheet Page 9 of 21

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			OMB NO	0.0938-039	
	THE LAN	OF CORRECTION .	IDENTIFICATION NUMBER:	A BU			(X3) DATE S	SURVEY	
ı		09G097		B. WING			-  ·		
	CAREC	PROVIDER OR SUPPLIER D 03		<del></del>	14	EET ADDRESS, CITY, STATE, ZIP CODE	01/2	24/2007	
L	(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	<del></del>		ASHINGTON, DC 20010			
	PRÉFIX TAG	REGULATORY OR LE	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	55 A =	(X5) COMPLETION DATE	
	W 249	As soon as the inter- formulated a client's each client must rec- treatment program of interventions and se- and frequency to sur	GRAM IMPLEMENTATION  disciplinary team has individual program plan, elive a continuous active consisting of needed rvices in sufficient number oport the achievement of the in the individual program plan	W 2	!49	See response to W159. The Director Disability Services will ensure that program staff implement continuous treatment as soon as the interdiscip has formulated the clients' program	QMRP and its active linary team	}	
		record review, the factories treatment inter- recommendations was	not met as evidenced by: views, observation, and cility failed to ensure that ventions and ere employed at every in the natural setting for	·					
	v s c c c c c c c c c c c c c c c c c c	staff fed the client. The client #1 had a feeding resented a document client's name) during the lient's name) during the weighted spoon poons of food. Further had vidual program plaurrent year indicated uring the lunch obserssistance employed the "How to assist the als."	07, at 11:50 AM, Client #1 his lunch. The direct care he surveyor asked the staff if g protocol. The staff t titled "How to assist (meals." The client should wer hand assistance to "pick h, and to feed himself 3 - 4 ar review of the client's in (IPP) objectives for the the same. At no time vation was hand over hand by the staff during the meal. (client's name) during the indicated that the client	·					
		nould receive verbal a	and hand over hand	· .					
	(F	- マーマン・ア・セリレルは V目(を)のわた へんちょ			_		1	1	

I M I EME	NT OF DEFICIENCIES	& MEDICAID SERVICES	<del></del>		OMB NO	MAPPROVE 0. 0938-039		
ND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILO	LTIPLE CONSTRUCTION DING	(X3) DATE : COMPL	SURVEY		
	<u></u> .	09G097	B. WING		-			
IAME OF	PROVIDER OR SUPPLIER		<del></del>		01/2	24/2007		
CAREC	O 03		s	TREET ADDRESS, CITY, STATE, ZIP 1447 OAK STREET, NW WASHINGTON, DC 20010	CODE			
(X4) ID PREFIX TAG	I GOVERNORM	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SMOULD BE ABOVE	(XE) COMPLETION DATE		
W 249	Continued From pa	ge 10		<u> </u>				
	directives about wheevery step. At no ti	at needs to take place for me during the lunch rbal directives given to the	W 24	9	·			
N 263	provide the recommassistance to the cli	nat during the snack pary 23, 2007, the staff did sended hand over hand ent.						
	CHANGE	OGRAM MONITORING &	W 263	See response to W124.		3/9/07		
	are conducted Olith	uld insure that these programs with the written informed , parents (if the client is a dian.			·			
	review, the facility far client's behavior inte the use of behavior r conducted with the w the client, parents (if	not met as evidenced by: n, staff interview and record iled to ensure that each rvention technique, including nodification drugs was ritten informed consent of the client is a minor) or legal vo clients in the sample (						
-	The findings include:		-					
r	estrictive measures	24. The facility failed to ent prior to the use of (psychotropic medications) #1's behavior support plan.						
2 e	2. Cross Refer to W 3	112. The facility failed to consent was obtained prior of sedation for Client #1						

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DEPAR CENTE	TMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES  & MEDICAID SERVICES				FORM	: 01/31/2007 APPROVED	)
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
· · · · · · · · · · · · · · · · · · ·		096097	B. WIN	G		01/24/2007		
CARECO				14	EET ADDRESS. CITY. SYATE, ZIP CODE 147 OAK STREET, NW /ASHINGTON, DC 20010		7/2007	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS	(X5) COMPLETION QATE	_
W 263	Cross Refer to Wobtain informed con restrictive measures and behavior supports.	124, 2. The facility failed to sent prior to the use of specification medication of plan for Client #2.	W 2	63				
W 312	must be used only a client's individual pro specifically towards	G USAGE  rol of inappropriate behavior is an integral part of the ogram plan that is directed the reduction of and eventual shaviors for which the drugs	W 3	12	See response to W212.		3/9/07	
	failed to ensure that modification medical appointmen	tions prescribed to complete ts was incorporated in the lan (IPP) for one of the two						
l	24, 2007 revealed th	s medical records on January at on February 9, 2006, tivan 3 mg prior to having						
	on January 24, 2007 not have a desensiti appointments. Revie Support Plan dated J24, 2007, failed to evaddresses the client's medical appointment sedative medication. The use of behavior necessity is a sedative medication.	tensed Practical Nurse (LPN), revealed that Client #1 did zation program for medical ew of Client #1's Behavior lanuary 3, 2007, on January idence a program that is non-compliant behaviors at its to justify the use of the There was no evidence that modification medications						

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Event ID: 1Y8P11

Facility ID: 09G097

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CENTE	RS FOR MEDICAR	H AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	: 01/31/200 APPROVE
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING	(X3) DATE S COMPLE	. 0938-039 URVEY ETED
		09G097	B. WING	S	-	
NAME OF F	PROVIDER OR SUPPLIER	1	<del>-\</del>	STREET ADDRESS, CITY, STATE, ZIP COD		4/2007
CARECO	0 03			1447 OAK STREET, NW WASHINGTON, DC 20010	E.	
(X4) ID PREFIX TAG	L CEACH DEFICIENC	ATEMENT OF DEFICIÊNCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE	JI h BE CROSS.	(X5) COMPLETION DATE
W 312	Continued From pa	age 12	W 31	2		<del> </del>
	prescribed to comp	olete medical appointments n the individual program plan (	, v S			
W 322		SICIAN SERVIÇES	W 32	2		
	The facility must pr general medical ca	ovide or obtain preventive and re.		See responses to W104, W124,	and W212.	3/9/07
·	facility failed provide for three of four clie Client #1, #2 and #	<i>'</i>				
٠. ا	Client #1 received a the record on Janua revealed that on Oc evaluated by his prin "not eating well for the PCP recommended	2007,at staff indicated that in upper GI study. Review of ary 24, 2007, at 10:40 a,m. tober 6, 2006, the client was mary care physician (PCP) for he past two (2) days." The that the client receive an an abdominal songers.		·		
.	he had not. The fac	Irse to ascertain if the client Inal sonogram, revealed that illy failed to ensure that he recommended procedure				
	anuary 24, 2007, at was evaluated by t it was recommend	#1's Medical records on tall:00 s.m. revealed Client # the Urologist on May 12, 2005 ed that the client be re- tr. Further review of the chart				

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Facility ID: 09G097

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES  MEDICAID SERVICES				FORM	01/31/2007 APPROVED
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X3) I	/I II TIE	PLE CONSTRUCTION ,	OMB NO	<u>. 0938-0391</u>
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU			(X3) DATE S COMPLE	
		09G097	B. Wil	NG_			
NAME OF	PROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CODE	01/2	4/2007
CAREC	O 03			14	47 OAK STREET, NW ASHINGTON, DC 20010		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECT		<del></del>
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	DE COACA	COMPLETION DATE
W 322	Continued From pa	ge 13	W	322		<del></del> _	
	failed to evidence to the urologist in 2000 January 24, 2006, a had not been sched	nat the client was evaluated by 6. Interview with the nurse on acknowledged that the client fulled for a urology visit in 2006 to ensure recommended		322			
	January 24, 2007 re evaluation on Decel heavy bleeding that a month continuous consultation report, therefore could not The gynecologist re an EMB (endometric further documented	ent #2's medical record on evealed she had a GYN for mber 29, 2005 for persistent occurred more than one time dy. According to the the client was uncooperative, be examined on that date, commend that the client have all blopsy). The gynecologist that the client would need sedure, likely under anesthesia	-				
	abnormal uteral blee abnormal uteral blee "Patient refused priosome sort of PO sec available, please for power of attorney or the EMBx (endometi QMRP and the nurse not be completed du representative to sig anesthesia and the pevidence Client #2 re in accordance with h	56. The facility falled to					
W 331	483.460(c) NURSING	SERVICES	14/ 25	24	•		
			W 33		See responses to W104, W124, and V		
- 441 CIVIO-200	37(02-99) Pravious Versions C	Ibsolete Event ID: 1Y8P11		Facility			 age 14 of 21

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				PRINTED	: 01/31/2007
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			•	FORM	APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE S	. 0938-0391 URVEY ETED
		09G097	B. WI	NG_			
NAME OF F	ROVIDER OR SUPPLIER		т.	ет	REET ADDRESS, CITY, STATE, ZIP CODE	01/2	<u>4/2007</u>
CARECO	0 03			1	1447 OAK STREET, NW NASHINGTON, DG 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	DE CDASS	(X5) COMPLETION DATE
W 331	Continued From page	ge 14		331		<del></del>	
	The facility must pro services in accordar	ovide clients with nursing nce with their needs.				•	
	This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure nursing services in accordance with the needs of one of two clients in the sample. (Client #2)				·	·	
	The findings include	:					
	<ol> <li>The facility's nurs Client #2's body weig as prescribed.</li> </ol>	ing services failed to ensure ghts were monitored weekly					
	January 22,2007 revorder revealed an orweight each week at March 14, 2006 Individed in the commendations re Weight Record reveately (169 pounds) November 23, 2006, indicated all weekly vocumented on the awas no evidence Cliemonitored weekly as Interdisciplinary Teartha primary care physician's orders to	Interview with the nurse veights should be aforementioned form. There ent #2's weight were recommended by the (IDT) and as prescribed by sician (PCP).  In gentless failed to monitor ensure that all approved					
,	changes in the physic documented.	cian's orders were	ī				

DEPAR CENTE	RTMENT OF HEALTH	AND HUMAN SERVICES  & MEDICAID SERVICES				PRINTE	D: 01/31/2007 AAPPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		PLE CONSTRUCTION	OMB NO (X3) DATE S COMPL	) <u>. 0938-0391</u> SURVEY
		09G097	B, WI	NG_			
NAME OF	PROVIDER OR SUPPLIER			P.T.	MARKA MARKANA	01/2	24/2007
CAREC	O 03			1	REET ADDRESS, CITY, STATE, ZIP CODE 447 OAK STREET, NW VASHINGTON, DC 20010		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID				
PREFIX TAG	REGULATORY OR LE	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF	IX.	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE I	DE CDOCC	(X5) COMPLETION DATE
W 331	Continued From page	ge 15	146	224		<del></del> -	<del> </del>
	On January 23, 200	7 at 10:17 AM Client#2 was	VV	331			1
	I onseived to be OAGL	Weight for height Interview			•		
	with direct care staff	on January 23, 2007		i	·		1.
	revealed that Client	#2 is prescribed a 1500 dist		J			ŀ
	loss. The staff share	es and to encourage weight					<b>' </b>
	calorie meal nattorn	ed the surveyor the 1500 which she stated is being		ĺ			
	followed for meals a	nd snacks provided to Client			-		
	#2. According to Cli	ent #2's annual nutrition			·		1
	assessment dated N	farch 1 2006 the client was 1		- 1			
	os inches tall. The c	lient's ideal hody waight		}			
	range was assessed	by the nutritionist to be 120		- }			1
	CO 156 POUNDS, FURT	PET TROOPED TENSOR TOWARDS		ĺ			
	caloring level of the	nmended a reduction in the		1			ŀ
	calories. According	diet from 1800 to 1500 to the March 14, 2006			-		]
	abblosed iudialdial :	Support Plan (ISD)			•		
	recommendations, th	ie intervention for weight loss		- 1			
1	SUDDICTOR SUPPLY 150	JU Calorie diet/Avaid		- 1			
	Concentrated Sweet	S/Cut food into hite size:		- }			
i	Review Quarterly. The	le review of physician's order		- 1		·	
1	HOWEVEL (3)160 DION	CO CVICIONES A Chango in AL.		ļ			
	met order HOW 1900	to 1500 calories was made.					' l
	3. The facility's nursi	ng services failed to ensure		- }	•		1
	mar Alleit #7 Health	KISK Management Disa					į
	openmented intelven	tions to address her					
	diabetes mellitus.						
	Medication administra	ation observations on					
1.	January 22 2007 of F	i:40 PM revealed Client #2					}
1	received a fingerstick	Interview with the		- [		ì	- 1
1 4	inedication flurse indi	Cated the finger ctick in					[
1.1	benomined petore pre	akfast and dinner to account					1
	iei bloog glucose. 11	16 Client Wee also above at 1					
	o de administelet (3)	UCODDADA 500 ma Doscal III					
1 3	compared tenesing [	18 Client is prescribed that 1					
ľ	nedication to treat he	sugar monitoring and the reliabetes. The review of	•				
		• 1	-		•	1	
RM CMS-2567	7(02-99) Pravious Versions Ob	edete Event ID: 1Y8P11		Espilit	y ID; 09G097 If continue		
					/ ID; USG0S/	14	

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				PRINTED	: 01/31/2007
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FORM	APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		LE CONSTRUCTION	(X3) DATE S	
		09G097	B, WIN	c			
NAME OF	PROVIDER OR SUPPLIER		<del></del>			01/2	4/2007
CAREC	0 03			14	SET ADDRESS, CITY, STATE, ZIP CODE 47 OAK STREET, NW ASHINGTON, DC 20010		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEPICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE DESCRIPTION OF THE APPROPRIATE DESCR	RE COASE	(X6) COMPLETION DATE
W 331	Continued From pa	ge 16	14/ 2	21		<del></del> -	
	the Health Risk Mar provide evidence th the client's diabetes	nagement Plan failed to at interventions to address mellitus were documented.	W 3	31			
	Client #2's audiolog completed timely.	sing services failed to ensure Ical assessment was					
	revealed that Client examination schedul Record review Indicate examination was initially but to wax accumulated audiologist referred of the wax. The audireturn for completion examination and recompossible after the Envealed the recommended to impaction of cerume the recommended Econducted timely to Client #2's audiologic	commendations as soon as NT visit. Record review mended ENT visit was mber 6, 2006. At that visit, used and removed a severe en. There was no evidence in appointment was ensure the completion of call examination as soon as					
	5. Cross Refer to Waservices failed to folloguardianship paperwoompletion of Client:  According to the Mar Client #2's Health Ris	ended by the audiologist.  124, 3. The facility's nursing ow-up timely on the status of rork needed for the #2 GYN procedure.  124, 3. The facility's nursing exits of rork needed for the rork needed for the #2 GYN procedure.  125, 3. 2006 nursing review, sk Management Plan is to address her alteration in					

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comfort related to dysmenorrhea. Further record review revealed Gyn follow-up for a endometrial biopsy (EMB) was recommended during the

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Facility ID; 09G097

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		E & MEDICAID SERVICES			FORN	0: 01/31/20 APPROVE
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ULTIPLE CONSTRUCTION DING	(X3) DATE S	
		09G097	B. WING	3		
NAME OF	PROVIDER OR SUPPLIER				01/2	24/2007
CAREC	O 03			STREET ADDRESS, CITY, STATE, ZIP COL 1447 OAK STREET, NW	DΕ	,
(X4) ID	5UMMARY STA	TEMENT OF DEFICIENCIES	- I	WASHINGTON, DC 20010	<del></del>	
PREFIX TAG	I LEAVE DEFICIENCE	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	II B AC ASSES	COMPLETIC DATE
W 331	Continued From pa	ige 17	W 33			<del> </del>
	reflected the need to guardianship paper documentation how details regarding the follow-up information guardianship. Intervindicated the facility locating the client's forms. Interview with on January 24, 2000 Client #2's MB had is lack of an authorized written informed cor 483.460(g)(2) COMITREATMENT  The facility must ensure the facility must ensure the services the needed for relief of the surface of the services of the ser	work. The review of nursing rever, failed to reveal the a nurses efforts to obtain an concerning the client's riew with the home manager and been unsuccessful in brother to sign the necessary of the nurse and record review revealed evidence that not been completed due to the difference representative to provide asent for the procedure.  PREHENSIVE DENTAL	W 356		that staff and aily dental car	3/9/07
1	review, the facility fail services for the main wo of the four clients wo of the four clients #2 and #3)  The finding includes:  Observation of Clients are the finterview with staff and revealed the finterview with staff and review with staff	not met as evidenced by: n, interview and record led to ensure treatment tenance of dental health for s residing in the facility. (  ent #2's teeth on January 22 ont teeth protruded forward, id record review indicated				
	equires supervision f	ush her teeth, however or thoroughness. Record				

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 01/31/2007 APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		AULTIF ILDING	PLE CONSTRUCTION	(X3) DATE S	<u>, 0938-0391</u> URVEY ETED
·		09G097	B. WII	NG		04/2	4/2007
CAREC	PROVIDER OR SUPPLIER		•	14	EET ADDRESS, CITY, STATE, ZIP GODE 47 OAK STREET, NW ASHINGTON, DC 20010	0 1/2	4/2007
(X4) ID PREFIX TAG	J (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	RE CROSS	(X5) GOMPLETION DATE
	review revealed Clie assessment on Octuber diagnosed heavy cathed the schedule an eeded treatment so was obtained from Market and the time, the clie moderate to heavy owas recommended. Client would be called to perform the needed preauthoriztion was interview with the nurevealed no evidence appointment to compressive as needed from the needed to perform the needed preauthoriztion was interview with the nurevealed no evidence appointment to compressive as needed from the needed to perform the needed from the needed to perform the needed from the needed	ent #2 had a dental recall ober 12, 2006. The dentist loulus deposits, generalized di that the client would be a appointment to perform the ervices after preauthoriztion Medicaid.  Certain the date of the last avices revealed Client #2 had ination on October 25, 2005. In the was diagnoses with reaching aloulus deposits. Scaling The dentist indicated the dito schedule an appointment ed treatment services after obtained from Medicaid. The client was given an object the dental cleaning greather of the appointments. In the client #2 received for the maintenance of her 24,3. Interview with the ardation Professional (QMRP) fication revealed Human IRC) Meetings are held sues related to client rights oview of HRC minutes dated excelled the committee as recommended for Client #3	. W:	356			
	he had a dental cons for extraction of a low	#d's clinical record revealed ultation on October 3, 2005 //er tooth. The dentist ble to obtain the radiograph					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED  (X3) DATE SURVEY COMPLETED  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  (X4) ID FROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (X4) ID PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG  (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  THE COMPLETED OF THE CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY DEFI	DEPAR CENTE	RTMENT OF HEALTH ERS FOR MEDICARE	AND HUMAN SERVICES  MEDICAID SERVICES			FORM	D: 01/31/200 MAPPROVE
NAME OF PROVIDER OR SUPPLIER  CARECO 03  STREET ADDRÉSS, CITY STATE, ZIP CODE  1447 OAK STREET, NW  WASHINGTON, DC 20010  (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W 356  Continued From page 19 of the tooth due to the client's failure to cooperate The dentist's limited examination of the client's	STATEMEN	VT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	- 1		(X3) DATE S	) <u>, 0938-039</u> Survey
CARECO 03  STREET ADDRESS, CITY STATE, ZIP CODE  1447 OAK STREET, NW  WASHINGTON, DC 20010  (X4) IP PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W 356  Continued From page 19 of the tooth due to the client's failure to cooperate The dentist's limited examination of the client's			09G097	B. Wil	NG		
CARECO 03  1447 OAK STREET, NW WASHINGTON, DC 20010  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W 356  Continued From page 19 of the tooth due to the client's failure to cooperate The dentist's limited examination of the client's	NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS CITY STATE ZIR CODE	01/2	24/2007
SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W 356  Continued From page 19  of the tooth due to the client's failure to cooperate The dentist's limited examination of the client's	CAREC	O 03			1447 OAK STREET, NW	<u>-</u>	
of the tooth due to the client's failure to cooperate  The dentist's limited examination of the client's	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY GITT	PREF	PROVIDER'S PLAN OF CORR IX (EACH CORRECTIVE ACTION SHOULD	I D DE COASC	(X5) COMPLETION DATE
Mouth however, revealed a buccal mucosa lesion /laceration and moderate plaque/calculus deposits. Tooth #17 was assessed to have a partial bony impaction. Full mouth rehabilitation in the operating room with extraction of the indicated teeth was recommended. The dentist however, stated that medical clearance must be obtained prior to the treatment being performed. Tylenol 650 mg by mouth ever 6 hours prn was recommended for pain. Interview with the home manager and the nurse on January 24, 2007 at 2: 47 PM indicated that the client had not returned to the dentist for the procedure due to the lack of written consent to complete the procedure. There was no evidence #3 received timely dental treatments services for the maintenance of his dental health.  W 441  The facility must hold evacuation drills under varied conditions.  W 441  The Director of Disability Services and the QMRP will devise the evacuation strategy and drill schedule such that drills occur under varied conditions. The QMRP will also ensure that the facility talled the part of the parties of the place in varied to the facility talled the parties of the place in varied to the facility talled the parties of the place in varied to the parties of the part	W 441	of the tooth due to the The dentist's limits mouth however, revideopsits. Tooth #17 partial bony impaction in the operating room indicated teeth was however, stated that obtained prior to the Tylenol 650 mg by necommended for partial bony impacts of the manager and the nutite dentist for the provideoperation of the provideoperation of the facility must hold varied conditions.  This STANDARD is Based on staff intervithe facility falled to he different egress area procedures.  The finding includes:  Observation of the farevealed that there we from the facility. On the facility records reveal used were the back at an interview with the second of the partial records reveal and interview with the second of the facility on the facility with the second of the parevealed were the back at an interview with the second of the pareveal of the pack at an interview with the second of the pack at an interview with the second of the pack at an interview with the second of the pack at an interview with the second of the pack at an interview with the second of the pack at an interview with the second of the pack at an interview with the second of the pack at an interview with the second of the pack at an interview with the second of the pack at an interview with the second of the pack at an interview with the second of the pack at an interview with the second of the pack at a second of the pac	the client's failure to cooperate and examination of the client's realed a buccal mucosa lesion rerate plaque/calculus. Was assessed to have a con. Full mouth rehabilitation in with extraction of the recommended. The dentist is medical clearance must be treatment being performed. Industry the client had not returned to occur the client had not returned to occur due to the lack of emplete the procedure. There received timely dental for the maintenance of his JATION DRILLS it evacuation drills under the mot met as evidenced by: iew and record verification, old evacuation drills using is as a part of the evacuation cilify on January 24, 2007, as three methods of egress January 24, 2007, review of alled that the primary exits and side doors of the facility, ite House Manager, on the		The Director of Disability Service QMRP will devise the evacuation drill schedule such that drills occur conditions. The QMRP will also expressed unscheduled drills take place in visualizations.	es and the strategy and ir under varie ensure that aried	d 3/1/07

CENTE	RS FOR MEDICAL	TH AND HUMAN SERVICES RE & MEDICAID SERVICES			FORM OMB NO.	APPROV 0938-03
ND PLAN (	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SI COMPLE	JRVEY
		09G097	B. WING		04/m	
NAME OF F	ROVIDER OR SUPPLIE	R	STR	EET ADDRESS, CITY, STATE, ZIP O		4/2007
CARECO	0 03		1 1	447 OAK STREET, NW /ASHINGTON, DC 20010	· <u>-</u>	
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W 441	Continued From	page 20	W 441			
	same day, it was egresses had not At the time of the	acknowledged that all areas been used during the fire drills, survey, there was no evidence rills were being held under	VV 441			
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Facility ID: 09G097

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AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU 09G097	ER/CLIA JMBER:	(X2) MULT A. BUİLDI B. WING	TIPLE CONSTRUCTION NG	(X3) DATE S COMPL)	URVEY ETED
NAME OF P	ROVIDER OR SUPPLIER	0.0001	STREET AD	DRESS OF	STATE, ZIP CODE	01/2	<u>4/2</u> 007
CARECO			1447 OAF	CSTREET, I	NW		
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R 000	INITIAL COMMEN This re-licensure s	UIVEV Was conducted	on	R 000			
	Four clients with vareside in this facility randomly selected the survey were ba group home and twifindings were base residential staff and	through January 24, 2 arying degrees of disa y. Two of the four clie for the sample. The f sed on observations to day programs. Als d on interviews with the d the day program stating including unusual including	2007. abilities ats were indings of at the to the he	· ·			
	25 4701.5 BACKGROUND CHECK REQUIREM  The criminal background check shall disclose criminal history of the prospective employee contract worker for the previous seven (7) ye in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check.		close the yee or 7) years, ective	R 125	The Director of Disability So that all potential employees s criminal background check p	submit a valid	,
	This Statute is not in The finding includes	met as evidenced by: ::					-
6	2007, revealed the G	nnel records on Janu HMRP failed to provi al background check ).	ido				
h Regulatio	on Administration						
カルナヘカシ や	(DECTORIO CT				TITLE		
E FORM	IRECTOR'S OR PROVIDE	RVSUPPLIER REPRESENTA	TIVE'S SIGNA	7: /= e-	<del></del>	(×	8) DATE

PRINTED: 01/31/2007 FORM APPROVED

		ilon Administr	ation		<del></del>			
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<del> </del>		<u> </u>	09G097		B. WING		01/2	4/2007
NAME OF F	PROVIDE	R OR SUPPLIER				STATE, ZIP CODE		
CARECO	03			WASHING	K STREET, STON, DC	NW 20010		
PREFIX TAG	RI	EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	em i	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	RE CDASS	(X5) COMPLETE DATE
I 00 <b>0</b>	INITI	AL COMMENT	rs		1000		· · · · · · · · · · · · · · · · · · ·	
	Four resider rander the sign of the finding resider	ary 23, 2007, to clients with value in this facility ornly selected to the control of the contro	drvey was conducted through January 24, 2 through January 24, 2 through January 26, 2 through 26, 2 through January 26, 2 through 26, 2 through 26, 2 thro	2007.  ubilities  nts were  indings of  at the  o the  ine				
I 180	Each admir needs Habili	GHMRP shall histrative suppo of the resider tation plans.	RATIVE SUPPORT  provide adequate ont to efficiently meet nts as required by the met as evidenced by: s:	∌ir	I 180	The Director of Disability Services coordinate with the Director of Nur QMRP, and outside supports such a Health Resources Partnership, to de support protocols and train/mentor staff to implement them. The Direct Disability Services will also perform Quality Assurance checks, and the	sing, the as the DC evelop healt all facility ctor of n weekly	h
I 188	3508.6 Docur, as req Habilit agreer availal persor	5 ADMINISTR nentation that uired by each ation Plan incl ments, receipt ble for review I	ncy Report - W192.  ATIVE SUPPORT  services have been president 's Individual luding contracts, venus, and paid bills shall by authorized regulationet as evidenced by:	dor be	l 188	Quality Assurance Department will monthly monitoring to ensure that s versed in all procedures and are impand documenting accurately and ap  The Director of Operations will ensure vendors have formalized agreement the GHMRP.	provide staff are we plementing propriately ure that all	11
	The fa agreer specia	cility filed to pr nent for the ph list, and the Ri	rovide evidence of a narmacist, the behav N sex therapist	vendor vior				
BORATORYI	DIRECTO	DR'S OR PROVIDE	ER/SUPPLIER REPRESENT.	ATIVE'S SIGN	ATURE	TITLE		X6) DATE

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Health I	Regula	<u>ition Administra</u>	atlon		_		FORM	APPROVED
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l 222	Then traini This	hg programs s	inuous, ongoing in-secheduled for all persecent as evidenced by	onnel.	1 222	The Director of Disability Services training and evidence of such training Emergency Preparedness/Disaster P Overview, Human Development, Cl Human Sexuality and Recreation.	ig on lan, MR	, .
	Information Inform	mation was pro al Retardation mation was pro es: gency Prepare	ovided to the surveyor Overview. Additional ovided on the following edness/Disaster Plan Development. Client is	illy g agency MR				
	3520. Profe and e develouservio deterioreside This see F	ng provided in nuous ongoing 3 PROFESSIC VISIONS saional service valuation, incluopmental levelues, and service oration or furthent. Statute is not rindings include ederal Deficier, W322, and Vision or Statute.	ncy Report - Citation	ent ent the	1401	The Director of Disability Services a Director of Nursing will review the records to ensure that all assessment individual program plans are coording consistent with the needs identified a Comprehensive Functional Assessments. The Director of Comprehensive Functional Assessments are reviewed and appropriately. The Director of Nursing will ensure that all Health Comprehensive Functional Assessments are reviewed and appropriately. The Director of Nursing conduct "grand rounds" at least monensure that medical and health support follow up are coordinated and proper implemented and documented.	client s and nated and in the ent and ctor of Care I updated ing will thly to orts and	
	Each (	GHMRP shall ;	provide habilitation, t	raining	1 422			
		110112-031						

STATEMENT OF DI AND PLAN OF COR		RECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI B. WING	<del></del>	(X3) DATE ( COMPL	ETED	
NAME OF PROVIDER		ER OR SUPPLIER			DDRESS, CITY, STATE, ZIP CODE		01/2	01/24/2007	
CARECO				1447 OAH WASHING	STREET, STON, DC	NW			
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1422	and a the re This The t	inued From page 2 assistance to residents in accordance with esident 's Individual Habilitation Plan. Statute is not met as evidenced by: finding includes: Federal Deficiency Report - Citation W249			1422				
	3523 Each that if prote chapt laws. This the fi	GHMRP resident rights of resident in accordater, and other accordater, and other accordater, and other accordater, and other accordates in accordate resident in accordate resident res	S RIGHTS  ence director shall e idents are observed ance with D.C. Law 2 applicable District an	ensure I and 2-137, this I'd federal	1500	The Director of Disability Ser that all staff ensure the rights of protected and promoted in accordistrict and Federal laws, and policies. The Director of Disawill provide training on rights promotion, and will ensure all are in compliance with District Laws and Basic Assurances as Council on Quality and Leader MRDDA.	of clients are ordance with the facility's bility Services protection and facility policies t and Federal defined by the	3/9/0	